Recovery: Changing From A Medical Model To A Psychosocial Rehabilitation Mode

by Mark Ragins, M.D.

Ever since Kraeplin defined schizophrenia, or dementia praecox, 100 vears ago, as a chronic, unremitting, gradually deteriorating condition, it has been difficult to talk credibly about or work towards recovery with severe mental illness. The relationship between treatment professionals, patients and their families has frequently been frustrating, unsatisfying, and noncollaborative often to the point of coercion. Clients and families are often waiting for their illnesses to go away, or be cured, in order to go on with their lives and are angry at professionals for not helping them, or doing anything for them, since their lives are not improving at all. At present, most people on all sides have abandoned the process entirely out of despair. Very few psychiatrists treat the chronically mentally ill and increasing numbers of patients are described as "treatment resistant" and families are "burned out" and disengaged. The result is the abandonment, neglect and deterioration we see all around us. All this hopelessness exists despite clear evidence of the growing efficacy of our treatments, and more benign outcomes than traditionally thought. I would argue that the problem may be as much in our conceptual model of treatment and recovery as in the inherent nature of the conditions. Schizophrenics in third world countries are regularly reported to have better outcomes than here. Also people with schizophrenia who explain their conditions spiritually, instead of medically, apparently fare better.

The medical model tends to define recovery in negative terms. Symptoms and complaints need to be eliminated. Illnesses need to be cured or removed. Patients need to be relieved of their conditions and returned to their premorbid, healthy, or more accurately not-ill state. A comfortable treatment relationship between powerful healing professionals and helpless patients complying with orders they need not really understand results in a clear recovery. This model tends to break down for chronic medical conditions. Striking examples can be found in most nursing homes. Even with common illness like hypertension, recovery is difficult to conceptualize within this model. Has a person who takes blood pressure medication permanently resulting in normal blood pressure recovered? How about a person who alters his diet, exercises, eats less salt, deals with stress better and normalizes his blood pressure without medication? Hypertension is often asymptomatic even untreated. How would we assess a person who has no treatment, lives a normal life, has high blood pressure throughout but never suffers any complications like strokes or heart attacks? If we were to move on to more complicated chronic illnesses like diabetes, psychiatrists' favorite medical analogy, the model would be even more inadequate in conceptualizing recovery.

For severe mental illness it may seem almost dishonest to talk about recovery. After all, the conditions are likely to persist, in at least some form, indefinitely. How can someone recover from an incurable illness? The way out of this dilemma is by realizing that, whereas the illness is the object of curative treatment efforts, it is the persons themselves who are the objects of recovery efforts. The medical model handles this by making it a two-step process. First, treat the illness, then rehabilitate the person. The net effect is often to delay recovery indefinitely while medical cures for the illness are being sought. There is also a discordance between the professionals focusing on the illness, while the people focus on their entire lives. This often leads to a serious communication barrier with many people complaining that their doctors don't talk to or listen to them. The two processes of cure and recovery are, although interrelated, not absolutely dependent on each other, and can and should be pursued concurrently.

A broader perspective can be obtained by examining other established treatment models that conceptualize the recovery process and the helping relationship in very different ways than the medical model. Within the 12-step model for treating substance abuse disorders, and increasingly other psychological conditions, people are "in recovery" if they admit .they are alcoholic, stay sober, and work a program. Just being a "dry drunk" really is not enough. Put into more theoretical terms these elements of recovery are:

1. Accepting having a chronic, incurable illness, that is a permanent part of them, without guilt or shame, without fault or blame.
2. Avoiding complications of the condition (e.g. by staying sober).

3. Participating in an ongoing support system both as a recipient and a provider.
4. Changing many aspects of their lives including emotions, interpersonal relationships, and spirituality both to accommodate their illness and grow through overcoming it.

People must take responsibility for their own recoveries, helping themselves for their own benefit. ("it won't work if you're doing it for someone else." "No one can do it for you.") Treatment professionals are eliminated entirely from the process replaced by "a higher power" and a network of sponsors and self-help groups.

Medical rehabilitation tends to conceptualize recovery more in terms of function than pathology. A person can recover from a stroke by being able to walk or talk again even though the brain cells are still damaged and can never be normal again. Neither permanent pathology, treatment, or adaptation invalidate a recovery if people have met their functional goals. Treatment professionals are therapists who act as coaches helping to design a rehabilitation plan in which they support the patients' efforts to achieve a series of functional goals. Their relationship often focuses around motivating and focusing the patients, own efforts to help themselves.

Within rehabilitation, there is more of a concordance between the professional and the patient, than within the medical model, because both are clearly focused on treating the person and not the illness. Patients can experience active recovery regardless of the state of their illness.

Spiritual healing is a more complex and diverse field. Recovery tends to depend upon first achieving internal changes conceptualized either spiritually (for instance, "open your heart to God" or "purify your soul") or in terms of transcendent health and balance (either internally as in "balancing yin and yang" or "detoxifymg your system" or externally as in "coming into peace with Mother Earth" or as in astrology). After achieving this state of "grace" or "balance" the illness is expected to be relieved automatically or "miraculously" This process of first achieving transcendent health and then relieving the illness is the exact opposite of the medical model where first the illness is treated and then the person can achieve higher goals. In fact, treating an illness medically first is often equated with betraying spiritual faith and therefore antagonistic to God and spiritual healing.

In mental health we tend to overtly exclude spiritual aspects of life and treatment although they may be very important to our clients. Even still, many clients will attribute their recoveries to someone "really believing in me" or "seeing something inside me that I couldn't see" or "really caring about me not just because it was their job." These moments, whether conceptualized spiritually or not, clearly impart a state of acceptance and love, prior to relieving the illness. We may not even realize this is happening, and usually have not designed the treatment plan or ..... relationship trying to maximize it, although it may be the most central factor in our clients' recoveries. Indeed, treating a person as a "case" or a collection of symptoms is generally perceived as highly dehumanizing and makes feeling "whole," "well," "loved," or even "understood" almost impossible.

Psychosocial rehabilitation is a growing movement in community mental health today. One of the main roots of psychosocial rehabilitation is the consumer movement which arose primarily as a reaction against the psychiatric establishment. The theory remains strikingly anti-medical model and many proponents are still very angry about the coercive, abusive, infantilizing, dehumanizing, isolating, condescending, stigmatizing, destructive aspects of traditional mental health systems. They have progressed from self-help groups to clubhouses, based on the Fountain House model, and the consumers have become "members" If not entirely member run, these programs generally have considerable consumer input with member governments, advisory board representation, and "consumer-staff."

"Empowerment" is the central concept as people work to help themselves. They take responsibility for developing coping skills and adapting to help themselves recover from mental illness, to become "survivors." The focus is on strengths rather than weaknesses, people rather than illnesses.

The other main root of psychosocial rehabilitation is psychiatric rehabilitation. As developed at Boston University, UCLA, and elsewhere, this approach features a "stress-vulnerability" model of mental illness.

Clients are taught skills to overcome deficits and to reduce stress in order for their illnesses to become less symptomatic and for them to become more functional. Skills taught include symptom management, social skills, vocational skills, activities of daily life, educational skills, etc. Vocational rehabilitation often emerges as a primary focus because in our society work is the single best way to obtain an identity other than that of a mental patient and to integrate into the community.

Options often range from agency-run training job sites to competitive community supported employment with a "choose-get-keep" model. Supported education and housing have developed along similar lines. These two roots, the consumer movement and psychiatric rehabilitation, are beginning to merge into a recovery-rehabilitation model with many shared goals and techniques.

The Village Integrated Services Agency, in Long Beach, where I work, has expanded the Psychosocial model to include both typical services like social, vocational, clubhouse and housing, and generally segregated services like money management/payee, substance abuse, case management teams, medication, crisis response and even hospitalization all within a managed care, capitated funding scheme.

The psychosocial rehabilitation model for treating severe mental illness can incorporate many useful aspects of the other conceptual models while excluding harmful aspects of the medical model. Instead of viewing recovery negatively, in terms of symptoms to be relieved, illnesses to be cured, and treatment and medication to be ended, recovery can be viewed positively in terms of things to be actually recovered. These things may be grouped into three broad categories:

1. Functions may be recovered - as in the ability to read, to sleep restfully, to work, to have coherent conversations, to make love, to raise children, to drive a car, etc.
2. External things may be recovered - as in an apartment, a job, friends, playing in a band, a spouse, a car, family relationships, stereo, TV, educational programs, etc.
3. Internal states can be recovered as in feeling good about oneself, peace, self-identity other than mentally ill, responsibility for oneself, etc.

Unfortunately, even the word recovery has inherent negative connotations implying that people will get back things they used to have but lost due to their illnesses and that they will, ideally, go back to the "good times'. There are, in fact, many legitimate recovery goals that are to get things people never had before their illnesses (if there was a "before"). The "good times" may more realistically be attained by going forward to the future rather than backwards to the past. Whether people actually had things their illness took from them or whether it took away the chance to get things that they had expected to get and visualized getting, they will often experience a strong sense of loss and victimization. Borrowing from the trauma recovery model, they must accept their victimization in order to stop being victims and become, instead, "survivors'. Those people who either never had any vision of themselves as ever having anything, or who remain permanently in the victim role will have great difficulty recovering. The medical model tends more often to perpetuate the idea of being a permanent victim of "a chemical imbalance" and to take away hopeful visions of the future, (e.g. "you'll never be able to work") than to promote recovery.

These positive sets of objectives on the path to recovery are clearly more associated with quality of life than with the medical model objectives. In fact the symptom levels and severity of illness levels bear little relationship to function or quality of life. Similarly, the common goal of getting off medication is often particularly counter productive in attaining a higher quality of life. Positive recovery objectives are also, in large part, able to be worked towards actively and collaboratively, and are generally observable and accountable, non-stigmatizing, humanizing, and hopeful.

Although professionals are excluded from 12-step programs, most spiritual recovery programs, and even most psychosocial rehabilitation and consumer-run mental health programs, the model does not require this exclusion. What does need to be excluded, instead, are the heavily ingrained medical model traits of professionals: professional distance, emotional detachment, absolute authority, strict hierarchies, invulnerability, etc. What does not need to be excluded is special knowledge, training, skills and experience, caring and even healing spirit. As alluded to before, psychosocial rehabilitation can help people recover regardless of their medical/clinical treatment.

Medication, psychotherapy and case management can all be successfully adapted to the psychosocial rehabilitation model. Medication prescription becomes a process of education, consultation and collaboration. Psychotherapy becomes a variety of therapeutic relationships in more natural settings and within more adult-to-adult relationships. Case management becomes personal service plan goal setting, support and facilitation. There is a need for more professionals to work in psychosocial rehabilitation settings to learn how to adapt their clinical treatment methods to the psychosocial rehabilitation model.

Many consumer groups speak of the need for "exits" from the mental health system and want to get out of treatment. This "negative recovery goal" is difficult to reconcile with the substantial ongoing benefit from treatment and medication many. clients receive. This conflict often leads to agonizing results. From a "positive view" of recovery those same "exits" are actually "entrances" .to our community. The need is not so much to leave treatment or medication as to enter life. "Community integration' something most programs do very poorly, if at all, is the door they are looking for. At the point of walking through that door we should find ourselves alongside our clients working to fight stigma and to improve our deteriorated communities.

The relationship between service provider, client, and family needs to be fluid and to change depending on the goals being most actively pursued. The service provider may need to be medical consultant, coach, mentor, friend, peer, advisor, sponsor, student, customer, fellow patient, political activist, or even confessor to best help a person recover. As we use various aspects of ourselves, clients will be exploring, rediscovering, even recovering, various aspects of themselves and becoming whole people.

This multifaceted, flexible relationship almost always feels more real, more human, and more reciprocal than the traditional professional-patient relation ship. The client feels more valued and the service provider feels less drained.

Most people with severe mental illness are not permanently incapacitated, infantile, helpless beings whom we need to protect. They may occasionally need that, but for the most part they can have dreams, hopes, plans and choices, take risks and be responsible for the consequences. Often times what we are preventing or protecting them from is actually the opportunity for change, growth, experiencing reality, self-confidence and, ultimately, recovery itself.

Every other aspect of their person besides "incapacitating illness" is often ignored and invalidated, and withers away from neglect. The "high risk-high support" and "focusing on strengths instead of weaknesses" philosophies of the psychosocial rehabilitation model reverse these harmful trends.

To move to a truly collaborative relationship, massive rethinking and retraining will be needed on all sides; professionals, clients, families, and even society in general. Although the medical model has frustrated and failed-us, it is still extremely strong, entrenched and pervasive. It is stunning how many of us, whether neighbors, police, teachers, landlords, crime victims, doctors, store owners or whomever, refuse to relate to people with severe mental illnesses as anything but walking symptoms and to mental health programs as anything but places to contain and control them.

Yet, the time for change appears to be upon us and with it, perhaps, the opportunity to enhance the quality of life for the whole community.

Mark Ragins, M.D. is a board certified psychiatrist specializing in community mental health, and one of the staff psychiatrists at the Village Integrated Service Agency in Long Beach, CA.

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